Getting to Safe, Affordable, Effective, Patient-Centered Care: The Role of Patient Care Experience Measurement

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Track: **How Organizations Are Using CAHPS Surveys**
Session: Health Plan Use of the CAHPS Clinician & Group Survey for Reporting and Quality Improvement
Date & Time: April 20, 2010, 9:30 am
Track Number: CAHPS T3_S1

Transformation Vision: 2016

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A health care system that provides safe, timely, effective, affordable, patient-centered care for everyone in Massachusetts.

Levers of Change

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Public Engagement

Legislative & Regulatory

Finance & Payment

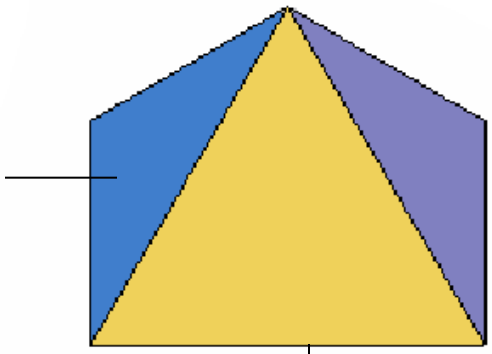
Governance

Quality & Safety Measurements

Information Technology

Organizational Readiness

A Balanced Portfolio of Measures



Patient Experience

Cost / Efficiency

Clinical Performance:

- **Process**
- **Outcomes**

A health care system that provides safe, timely, effective, affordable, patient-centered care for everyone in Massachusetts.

Guiding Principles in Selecting Performance Measures for "High Stakes" Use

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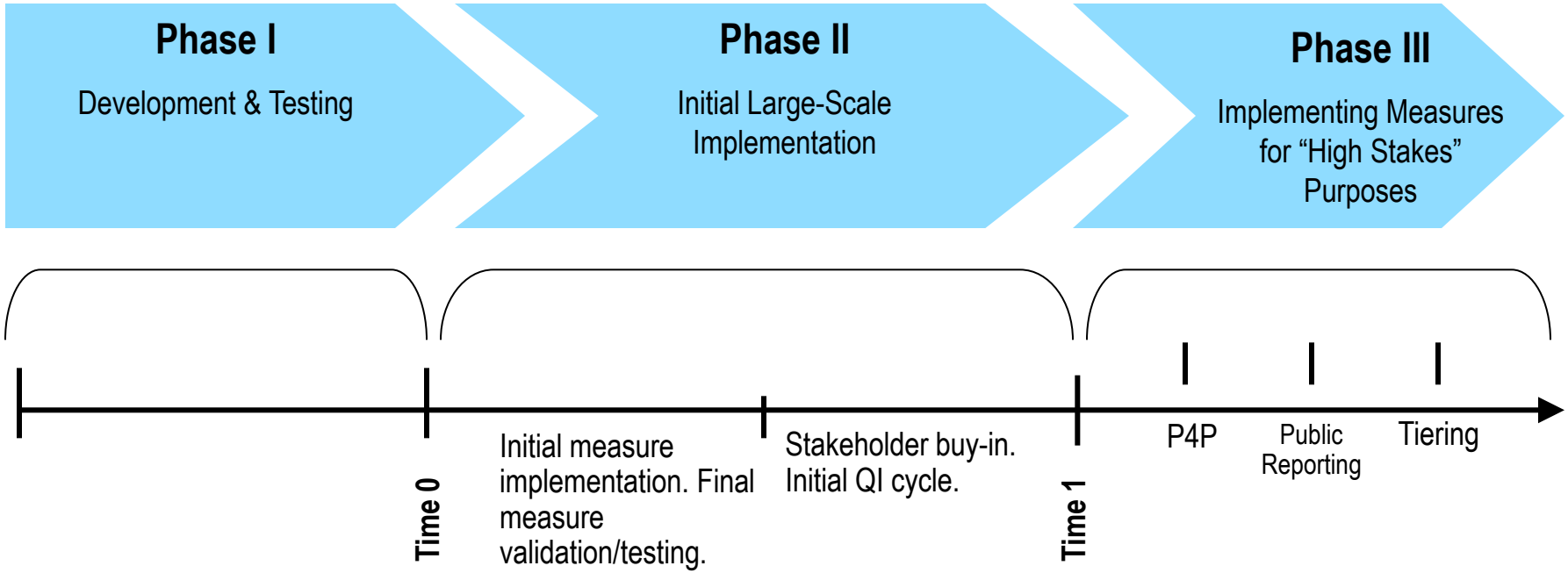
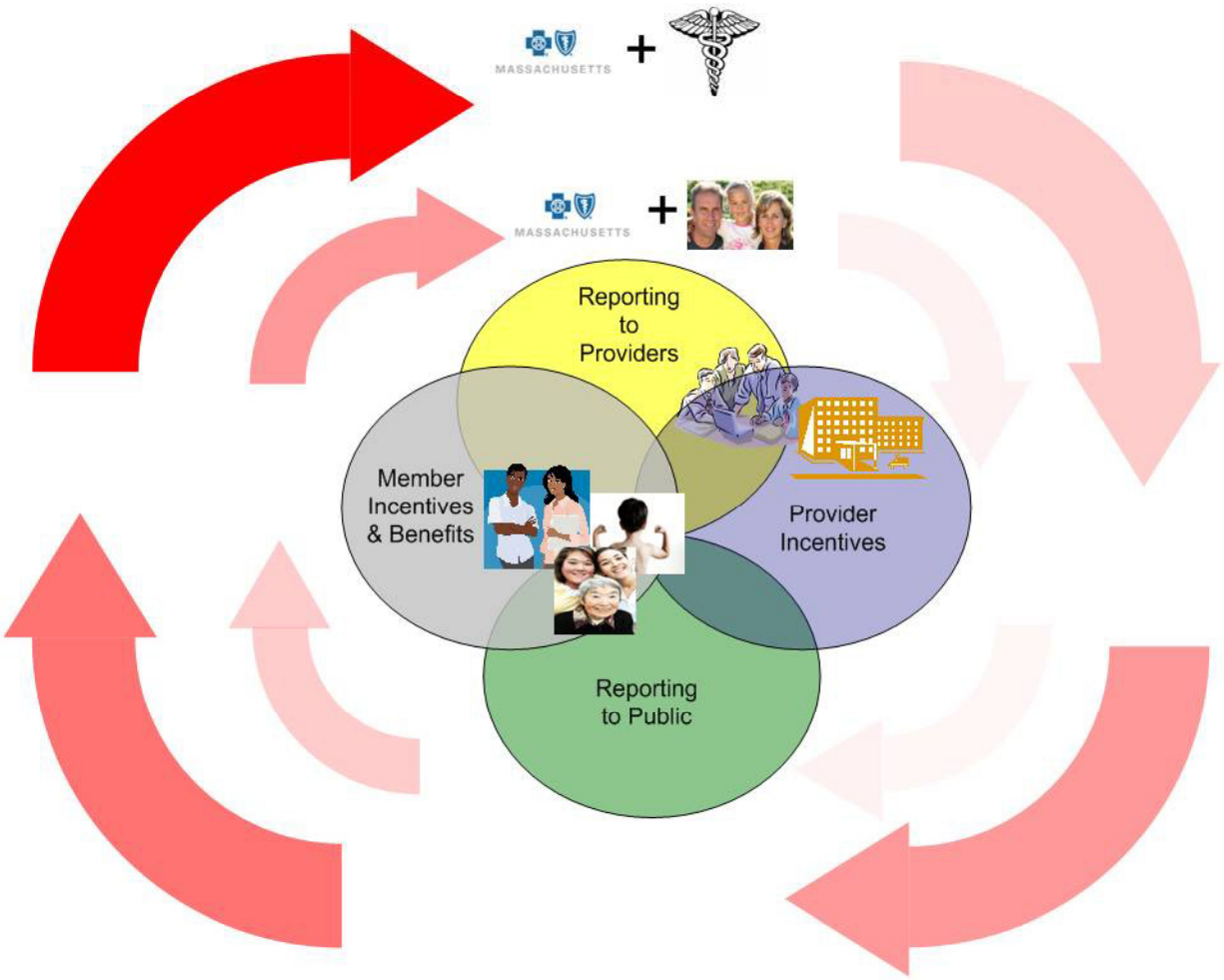
- Wherever possible, our measures should be drawn from nationally accepted standard measure sets.
- The measure must reflect something that is broadly accepted as clinically important.
- There must be empirical evidence that the measure provides stable and reliable information at the level at which it will be reported (i.e. individual, site, group, or institution) with available sample sizes and data sources.
- There must be sufficient variability on the measure across providers (or at the level at which data will be reported) to merit attention.
- The must be empirical evidence that the level of the system that will be held accountable (clinician, site, group, institution) accounts for substantial system-level variance in the measure.
- Providers should be exposed to information about the development and validation of the measures and given the opportunity to view their own performance, ideally for one measurement cycle, before the data are used for "high stakes" purposes.

Staged Development & Use of Performance Measures



Advancing Quality and Safety Through Our Performance Measurement and Reporting Programs



Key Components of the Alternative Contract Model

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Unique contract model:

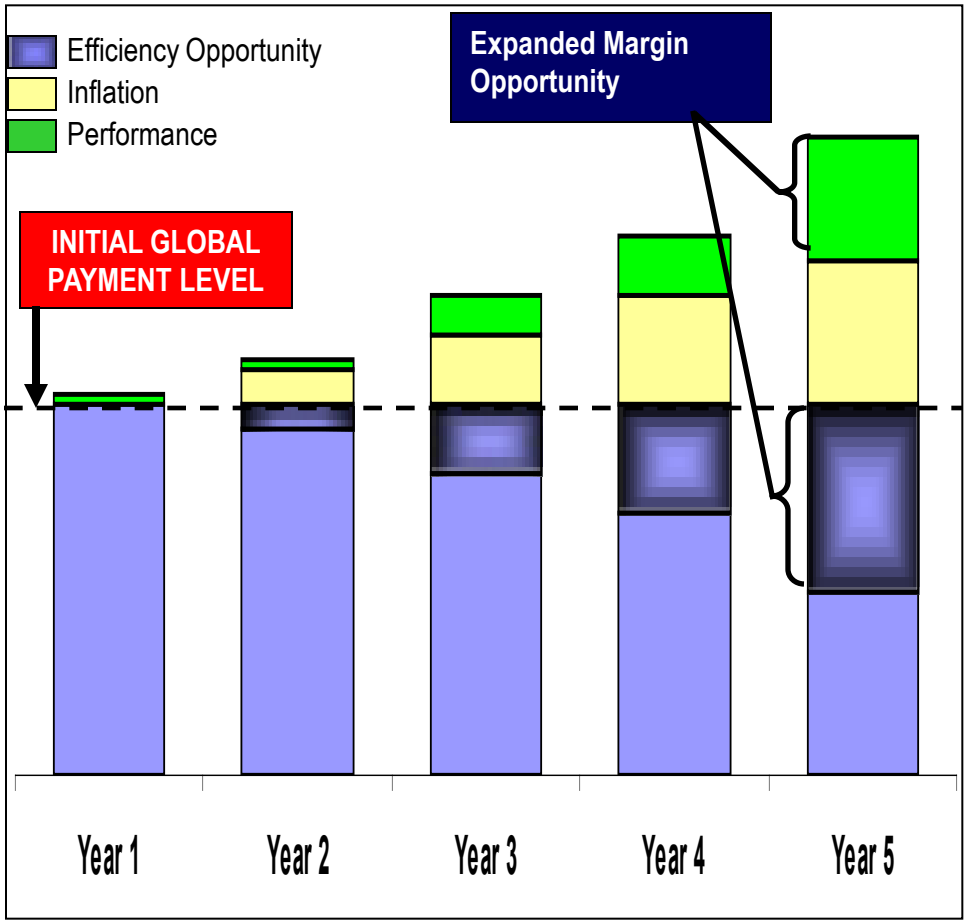
- Physicians & hospital contracted together as a "system" – accountable for cost & quality across full care continuum
- Long-term (5-years)

Controls cost growth

- Global payment for care across the continuum
- Annual inflation tied to CPI
- Incentive to eliminate clinically wasteful care ("overuse")

Improved quality, safety and outcomes

- Robust performance measure set creates accountability for quality, safety and outcomes across continuum
- Substantial financial incentives for high performance (up to 10% upside)



Ambulatory Measures

	Measure	Score	Weight
Process	**Depression**		
	1 Acute Phase Rx	2.5	1.0
	2 Continuation Phase Rx	1.5	1.0
	Diabetes		
	3 HbA1c Testing (2X)	3.0	1.0
	4 Eye Exams	1.0	1.0
	5 Nephropathy Screening	1.2	1.0
	Cholesterol Management		
	6 Diabetes LDL-C Screening	2.8	1.0
	7 Cardiovascular LDL-C Screening	2.1	1.0
	8 Breast Cancer Screening	1.2	1.0
	9 Cervical Cancer Screening	1.3	1.0
	10 Colorectal Cancer Screening	2.4	1.0
	Preventive Screening/Treatment		
	Chlamydia Screening		
	11 Ages 16-20	3.1	0.5
	12 Ages 21-25	1.8	0.5
	Pedi: Testing/Treatment		
	13 Upper Respiratory Infection (URI)	1.6	1.0
	14 Pharyngitis	1.4	1.0
	Pedi: Well-visits		
	15 < 15 months	2.6	1.0
	16 3-6 Years	2.0	1.0
	17 Adolescent Well Care Visits	1.5	1.0
Outcomes	**Diabetes**		
	18 HbA1c in Poor Control	3.2	3.0
	19 LDL-C Control (<100mg)	2.4	3.0
	Hypertension		
	20 Controlling High Blood Pressure	1.3	3.0
	Cardiovascular Disease		
	21 LDL-C Control (<100mg)	2.4	3.0
Patient Exper.	**Patient Experiences (C/G CAHPS/ACES) - Adult 3**		
	22 Communication Quality	1.9	1.0
	23 Knowledge of Patients	1.9	1.0
	24 Integration of Care	2.1	1.0
	25 Access to Care	2.4	1.0
	Patient Experiences (C/G CAHPS/ACES) - Pediatric 3		
	26 Communication Quality	1.0	1.0
	27 Knowledge of Patients	1.5	1.0
	28 Integration of Care	2.5	1.0
	29 Access to Care	2.8	1.0
Experimental	30 Experimental Measure A	5.0	1.0
	31 Experimental Measure B	5.0	1.0

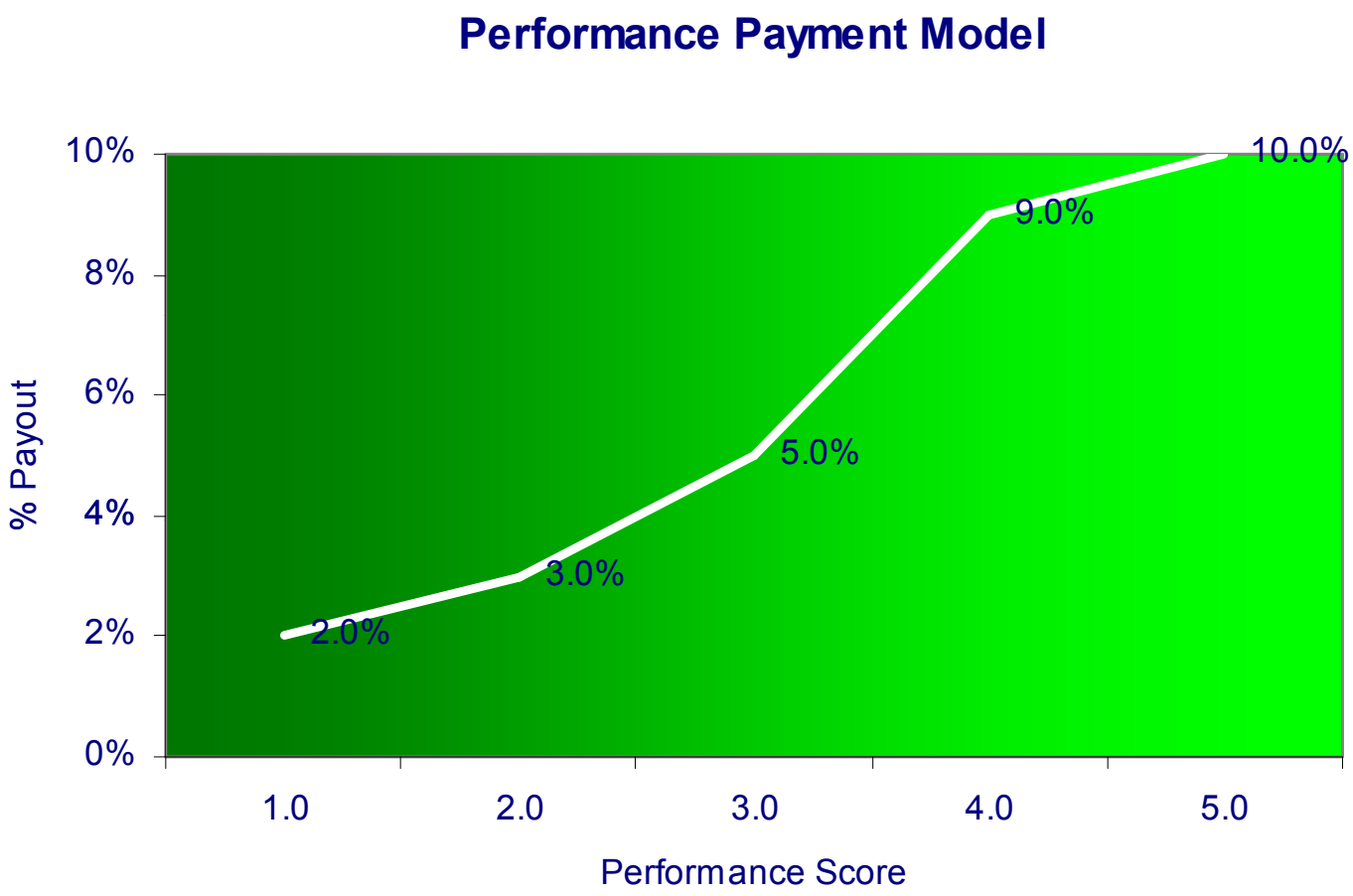
Hospital Measures

Measure		Score	Weight
AMI			
1	ACE/ARB for LVSD	2.0	1.0
2	Aspirin at arrival	2.5	1.0
3	Aspirin at discharge	1.5	1.0
4	Beta Blocker at arrival	1.5	1.0
5	Beta Blocker at discharge	1.3	1.0
6	Smoking Cessation	1.0	1.0
Heart Failure			
7	ACE LVSD	1.3	1.0
8	LVS function Evaluation	1.0	1.0
9	Discharge instructions	1.8	1.0
10	Smoking Cessation	3.0	1.0
Pneumonia			
11	Flu Vaccine	2.5	1.0
12	Pneumococcal Vaccination	2.9	1.0
13	Antibiotics w/in 4 hrs	1.4	1.0
14	Oxygen assessment	1.0	1.0
15	Smoking Cessation	3.1	1.0
16	Antibiotic selection	3.0	1.0
17	Blood culture	3.5	1.0
Surgical Infection			
18	Antibiotic received	1.3	1.0
19	Received Appropriate Preventive Antibiotic	1.4	1.0
20	Antibiotic discontinued	3.0	1.0
21	In-Hospital Mortality - Overall	3.0	1.0
22	Wound Infection	2.1	1.0
23	Select Infections due to Medical Care	2.8	1.0
24	AMI after Major Surgery	2.4	1.0
25	Pneumonia after Major Surgery	3.4	1.0
26	Post-Operative PE/DVT	2.0	1.0
27	Birth Trauma - injury to neonate	1.0	1.0
28	Obstetrics Trauma-vaginal w/o instrument	1.5	1.0
Hospital Patient Experience (H-CAHPS) Measures			
29	Communication with Nurses	4.0	1.0
30	Communication with Doctors	3.0	1.0
31	Responsiveness of staff	2.5	1.0
32	Discharge Information	2.8	1.0
33	Experimental Measure C	5.0	1.0

Weighted Ambulatory Score	2.2	Weighted Hospital Score	2.3

Aggregate Score 2.3

Performance Achievement Model



Key Components of the Alternative Contract Model

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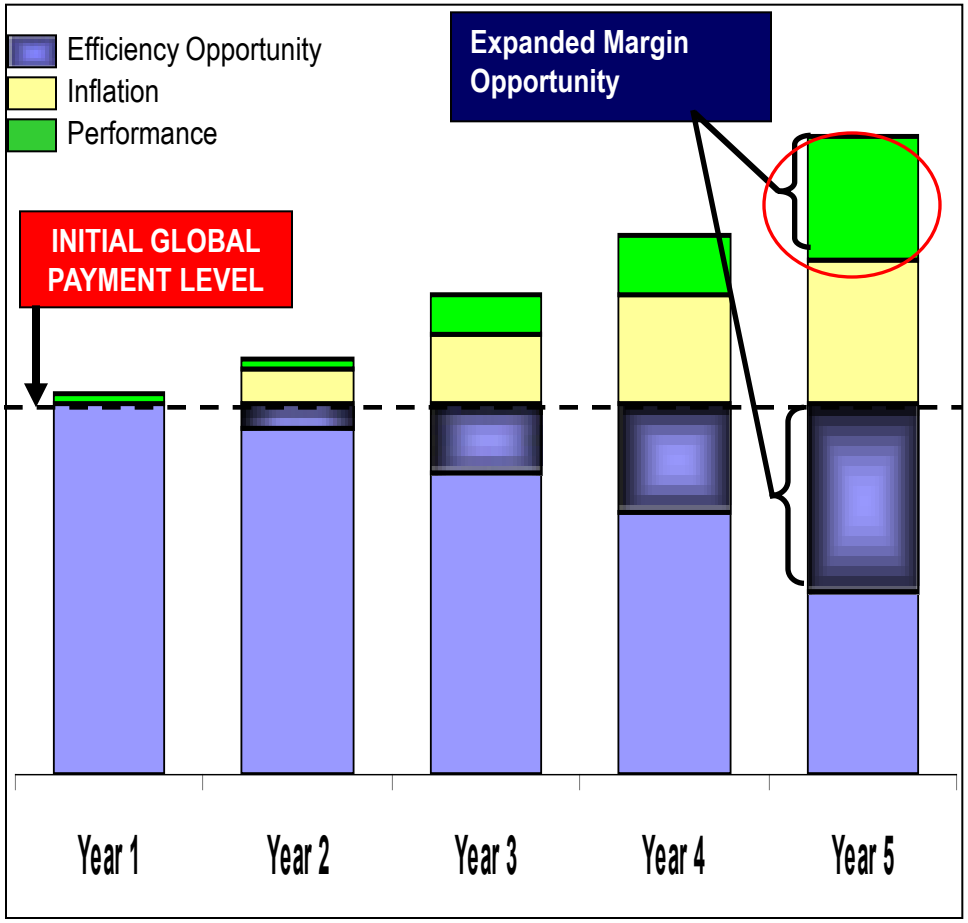
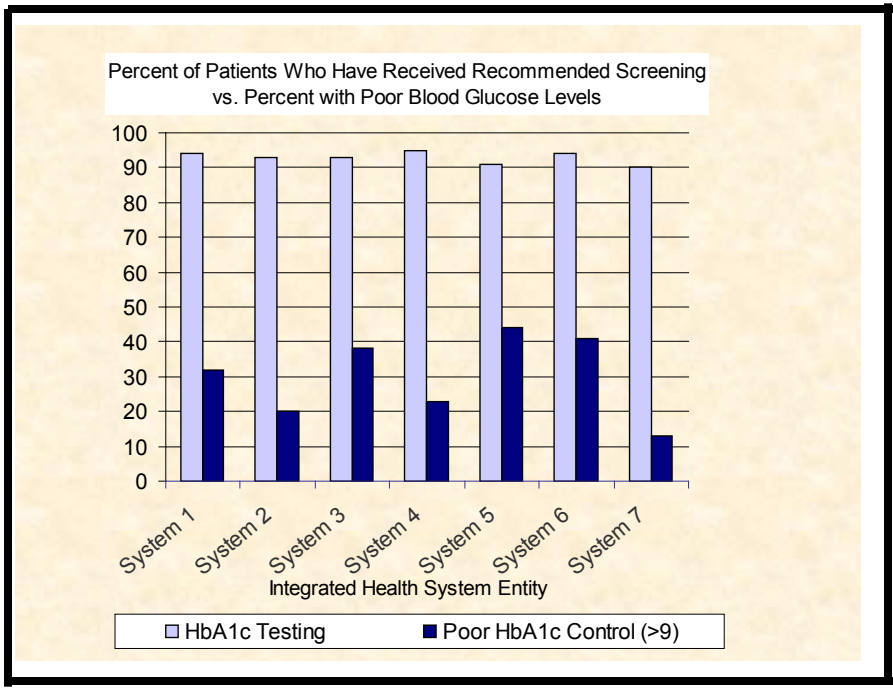
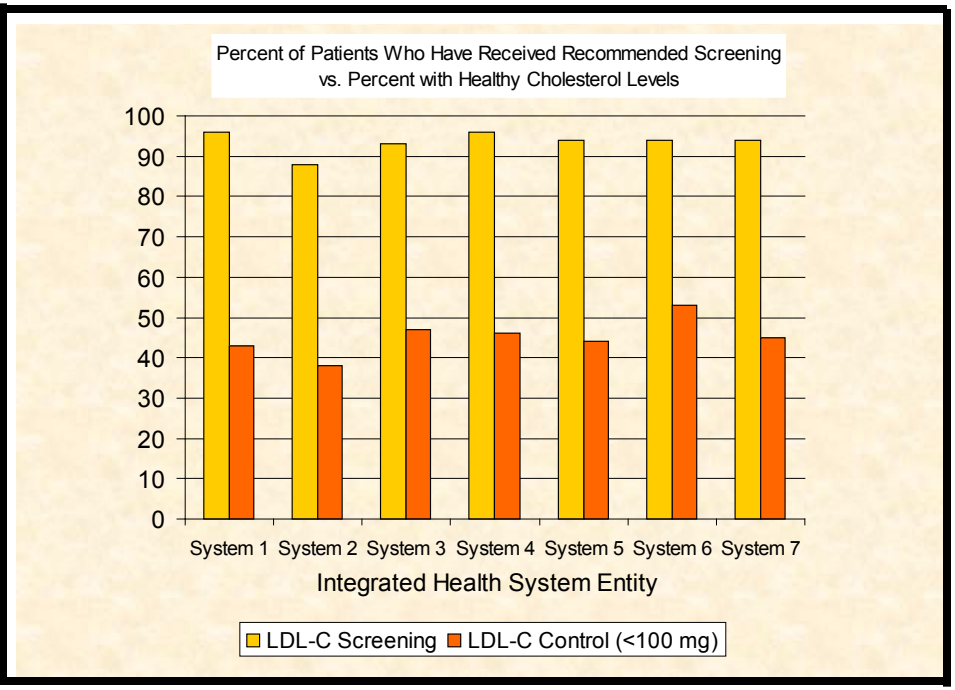
Performance Improvement:
Clinical Process, Clinical Outcomes, Patient Experience



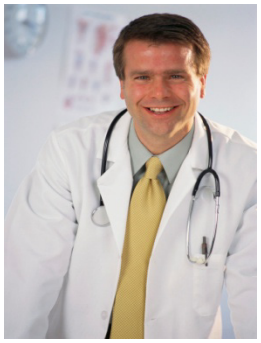
Diabetes Care:
Process is nearing perfection, outcomes are far from it





Source: MHQP, 2005 HEDIS process and outcomes measures

Barriers to Adherence



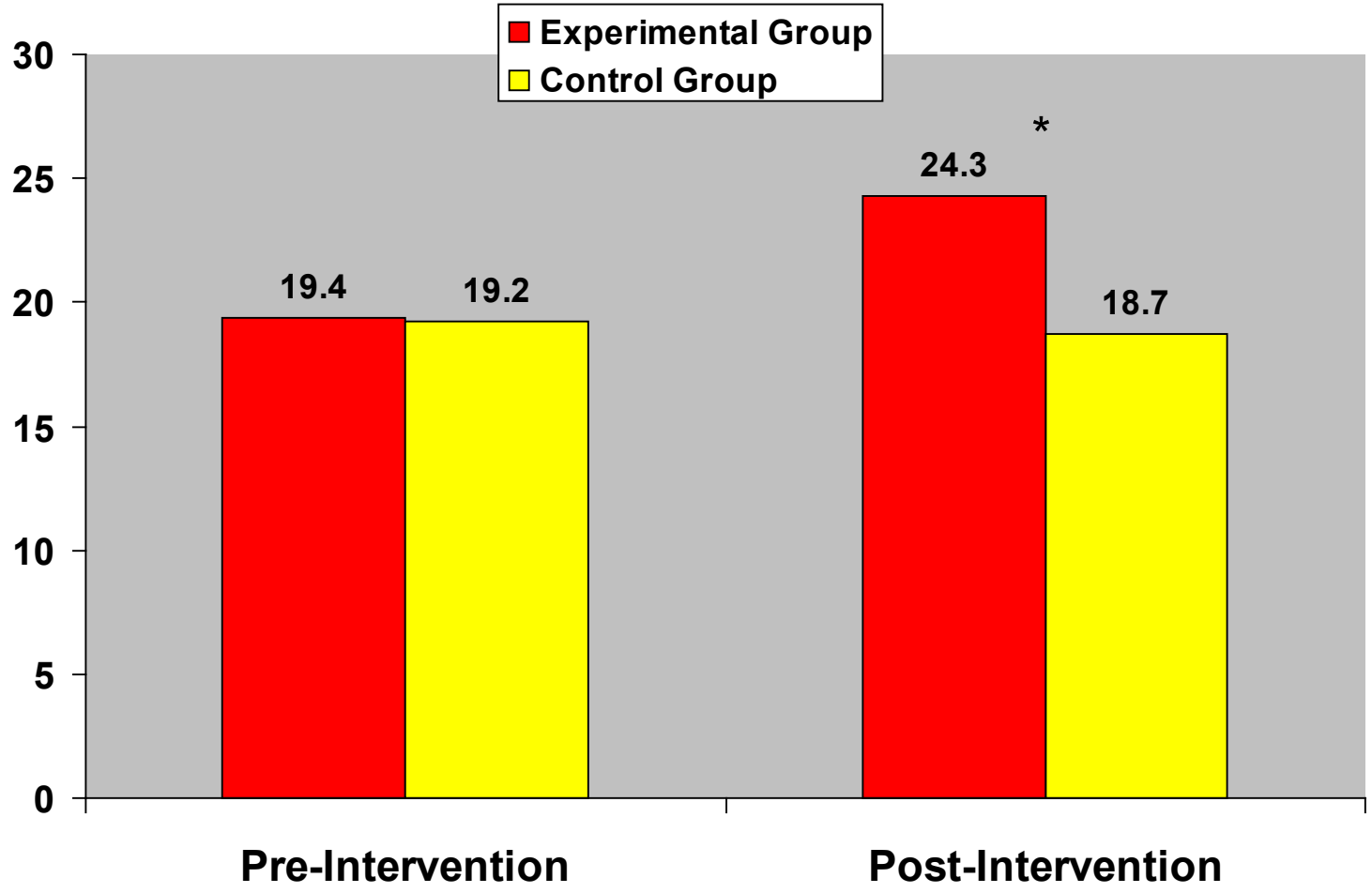
Cognitive

Financial

Logistical

Motivational

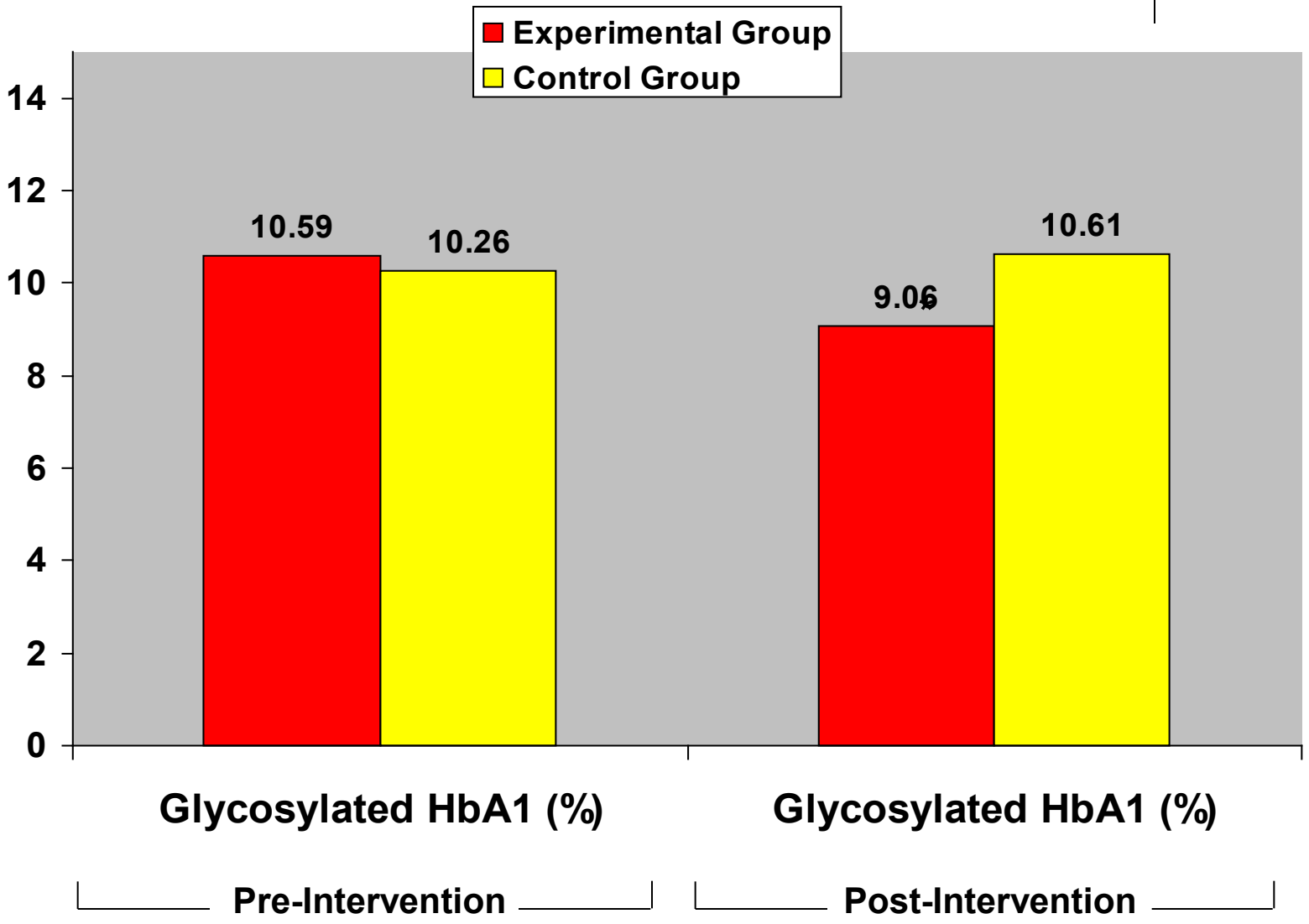
Patient Preference for Active Involvement in Medical Decision-Making: Effect of a Patient Involvement Intervention



Greenfield, S., et al. Annals of Internal Medicine, 1985; 102:520-528

* p<0.001

Effect of a Patient Involvement Intervention on Diabetes Control



Greenfield, S., et al. J Gen Intern Med, 1988; 3:448-457

* p<0.001

How "Improvable" Are Patient Experience Measures?

Challenges of Sustaining Improvements

"My trouble is that the energy for this action group died a quiet death. There really isn't anything to report. The administrator never really came on board and without his support the rest of the team lost enthusiasm."

--Participant in Patient-Centered Care Collaborative

Outcomes for Which Links to Clinical Relationship Quality are Established

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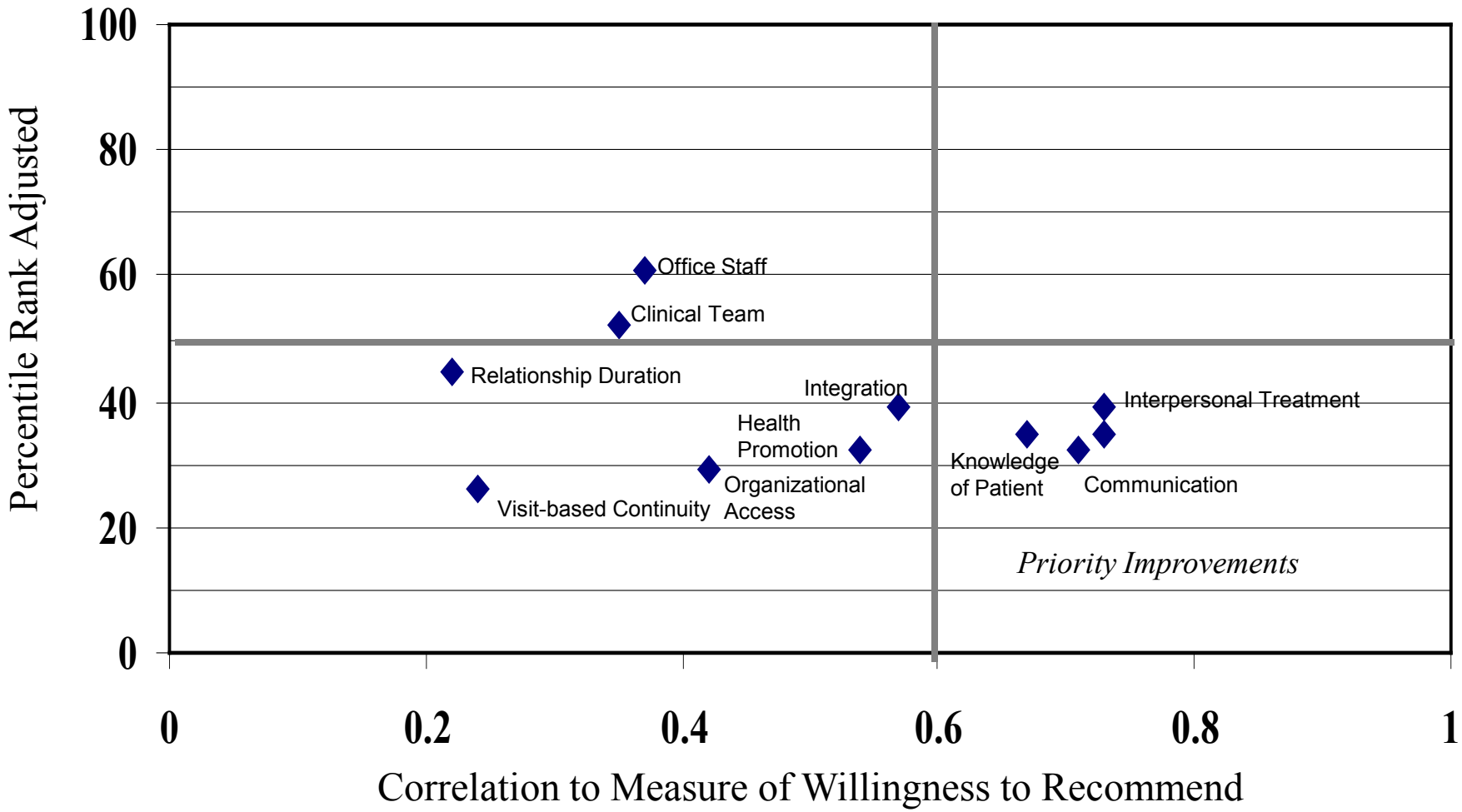
"Business" Outcomes

- Loyalty to the practice (voluntary disenrollment)
- Malpractice Risk
- Recommending the practice

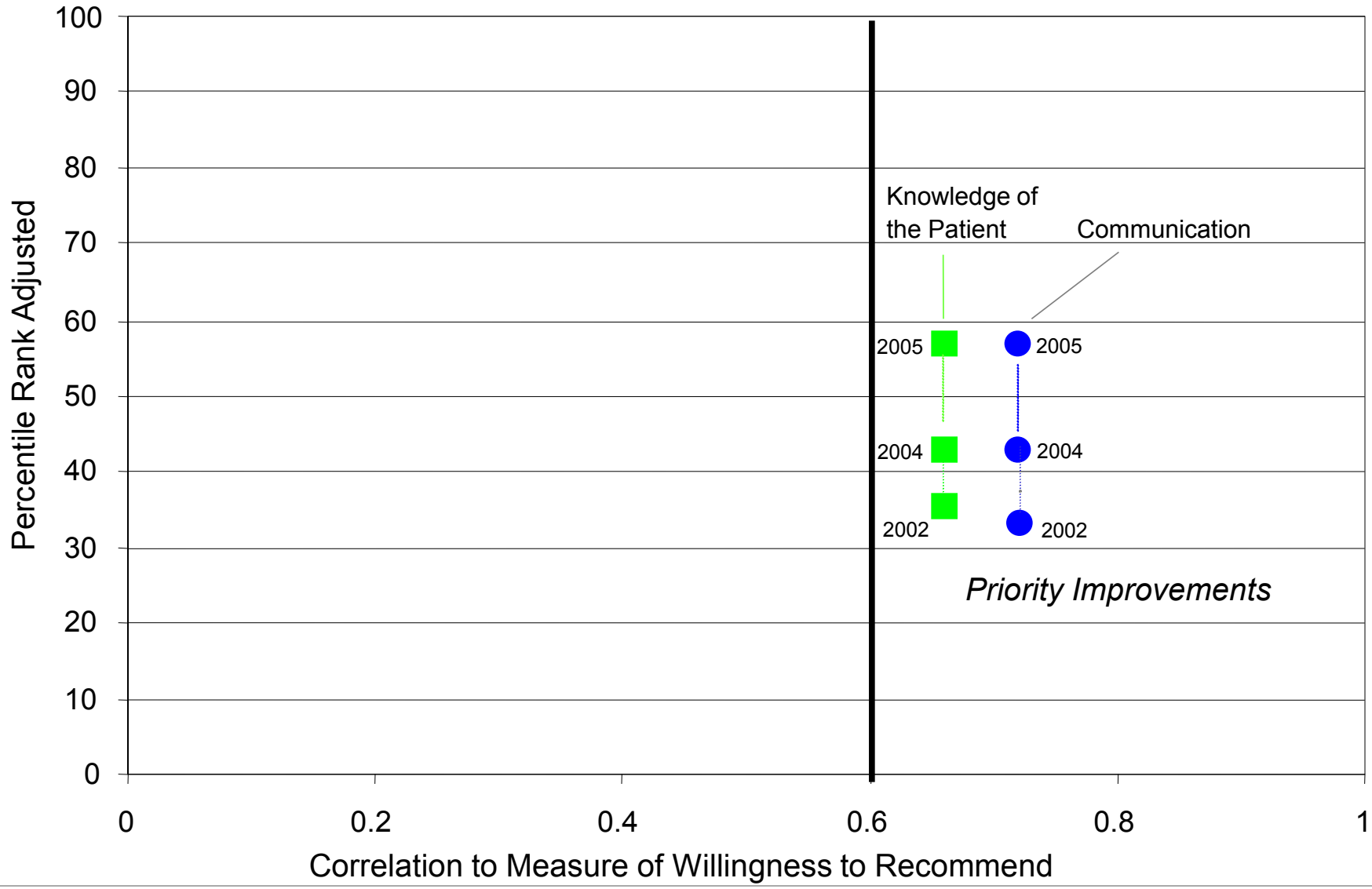
Health Outcomes

- Adherence to Clinical Advice
- Symptom Resolution
- Improved Clinical Indicators

What Drives Patients' Willingness To Recommend And How Are We Doing (2002)



Improving Patients' Care Experiences:
Changes in 2 Important Metrics: Jan 2002 – Jan 2005



What Were the Critical Elements of Success?

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Senior leadership vision and steadfast commitment

- "This is who we are!"
- Discussion at regular meetings and in conversations at every level of the organization

Measurement

- Regularly reported results (MD-level, practice-level, system-level)

System-level changes

- Scheduling templates, phone scripts, prioritizing continuity

External momentum toward public reporting

Whole-practice vs. Individually-Focused Improvement Strategy

- Supported by combination of group & individual-level data

Communication Skills Training: Randomized Trial

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Brief skills training for CA physicians with poor performance on statewide survey

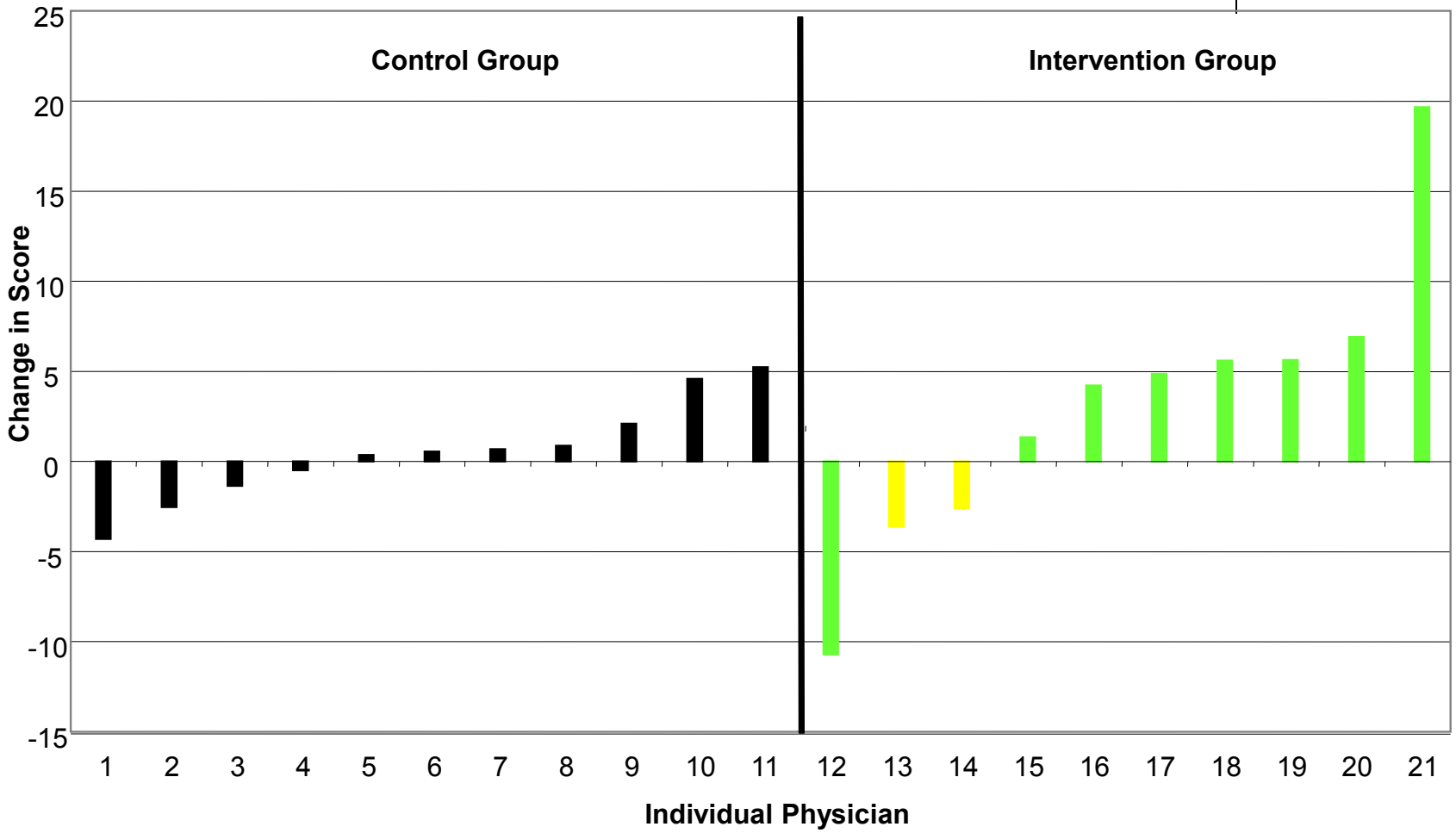
- Context: P4P and public reporting of group-level performance
- 3-hour evening session, 2 follow-up telephone calls
- Intervention group: 8 PCPs in group practice and 3 solo subspecialty docs
- Control docs matched in specialty, practice size, location and scores

Significant improvement in "communication" scores among intervention group

- No significant change among 2 of 3 docs in solo practice
- Collective experience may have helped by creating an environment supportive of (even expecting!) new behaviors, application of new skills

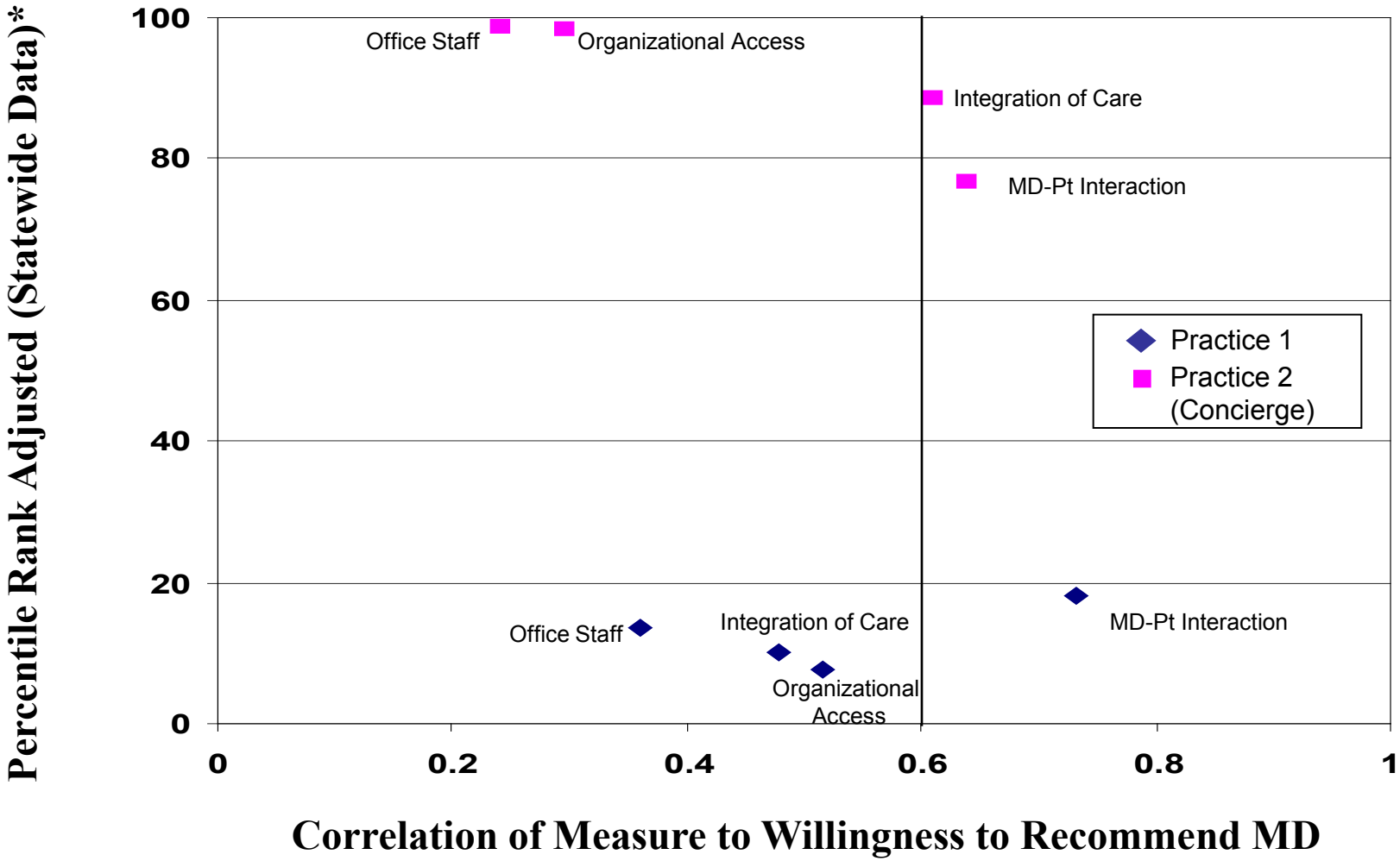
Unintended consequence: intervention docs reported renewed enjoyment of doctoring

Change in Quality of Physician-Patient Interaction Scores, by Physician and Study Group



Source : Rodriguez et al 2008 BMC Medical Education 2008

Comparison of Traditional vs. Concierge PCP Practice: Same Physicians in Different Office Setting



Based on data collected from 4 different physicians who practice at both sites (Practice 1 & Practice 2).
*Results are adjusted for clustering of physicians.

Source : The Patient: Patient-Centered Outcomes Research, In Press

Summary

- Without measurement, we don't know where we are on the journey
- But imprecise measurement used in "high stakes" ways undermines our collective efforts
- Getting to "high stakes" implementation with reliable, valid measures does not have to take long
- Much is available and appropriate for high stakes uses already – but substantial and important gaps in our national measurement portfolio remain
- Early evidence of "improvability" is encouraging – even on measures that go beyond "process of care"
  - …but requires broad organizational engagement, leadership and sustained effort
- Getting to safe, effective, affordable, patient-centered care will require ongoing use of valid, reliable performance measures, employed in ways that engage and align the interests of clinicians, patients, and health care institutions.

For More Information

Doctor and the Doll by Norman Rockwell

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